Department of Health Services
Presumptive Eligibility Support Unit
P.O. Box 942732
Sacramento, CA 94234-7320

QUALIFIED PROVIDER APPLICATION FOR PRESUMPTIVE ELIGIBILITY PARTICIPATION

This is an application for a Medi-Cal provider to become a Qualified Provider for purposes of offering Presumptive Eligibility to your pregnant patients. You must be a Medi-Cal provider in good standing and provide prenatal services to qualify for Presumptive Eligibility participation. If you do not have a current Medi-Cal provider number, but are interested in participating, please contact the Department of Health Services Provider Enrollment Unit at (916) 323-1945.

FOR OFFICIAL USE ONLY

Date Received: _____

PE Number: _____

Authorization Code: _____

PART I

PLEASE ENTER YOUR MEDI-CAL PROVIDER NUMBER HERE: _____

(Must be current and the same number as used for the name listed below.)

PART II

1. Name of provider or group (name must be the same as used for current Medi-Cal Provider Number)	Other name (if any used for provider services)	
2. County	Telephone number(s) ( ) ( )	FAX number ( ) ( )
3. Mailing address (street address for materials delivery–No P.O. Box)	City	ZIP Code
4. Contact person	Telephone number(s) ( ) ( )	FAX number ( ) ( )
5. Please estimate the number of pregnant patients your practice sees each month that are not covered by health insurance or Medi-Cal at the time of their initial pregnancy visit.	Of this number, how many do you expect will need Spanish language forms?	

PART III

1. Do you participate in the Comprehensive Perinatal Services Program (CPSP)? ☐ Yes ☐ No

   NOTE: If you are not currently a CPSP provider, you may get information on how to enroll by contacting the California Department of Health Services, Maternal and Child Health Branch at (916) 657-1347.

2. Do you participate in the Family P.A.C.T. (Planning, Access, Care, and Treatment) Program? ☐ Yes ☐ No

   NOTE: If you are not currently a Family P.A.C.T. provider, you may get information on how to enroll by contacting the California Department of Health Services at (800) 257-6900.

PART IV

CERTIFICATION

I hereby certify that all the above information is true and accurate to the best of my knowledge.

Signature	Title of Authorized Agent	Date

All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government Code, Section 6250, et seq.

PRESUMPTIVE ELIGIBILITY
QUALIFIED PROVIDER RESPONSIBILITIES AND AGREEMENT

I understand that my responsibilities as a Qualified Provider include:

- Offering the Presumptive Eligibility (PE) program to my pregnant patients without health coverage or Medi-Cal;
- Screening interested patients for income eligibility via the prescribed PE forms and guidelines;
- Issuing eligible applicants a PE card and the one-page Medi-Cal application form, issuing replacement cards to recipients upon request;
- Renewing the PE card when the woman presents a copy of her timely application for Medi-Cal or California Work Opportunity and Responsibility to Kids (CalWORKs);
- Informing the pregnant patient at the time of the PE determination that she must file her Medi-Cal (or CalWORKs) application at her local county welfare office within a specified period of time in order for her PE to continue;
- Assisting the pregnant patient in completing her one-page Medi-Cal application if needed;
- Providing a written statement to the applicant if she is ineligible for PE, and informing her that she may still file for Medi-Cal (or CalWORKs) at the county welfare department;
- Notifying the Department of Health Services within five working days with the required information on those patients eligible for Presumptive Eligibility and those not eligible due to a negative pregnancy test;
- Maintaining organized records of PE applications for three years from the last date of billing, making these records available to the Department of Health Services upon request, and permitting periodic Department review of the records with adequate notice from the Department;
- Attending PE training and keeping current with changes affecting PE through provider bulletins, notices and/or further training.

I, (print name) _____, agree to cooperate with the Department of Health Services in complying with the above Qualified Provider responsibilities. I am aware that if I do not comply with these responsibilities and the PE guidelines as outlined in the Medi-Cal Provider Manual, I may lose my status as a Qualified Provider. I agree to notify the Department of Health Services in writing of any changes in my application information at least 10 days prior to the effective date of the change.

_____	_____	_____
Signature	Title of Authorized Agent	Date